ASSEMBLY BILL No. 1181

Introduced by Assembly Member Escutia

February 28, 1997

An act to amend Section 1345 of the Health and Safety Code, and to amend Section 14016.5 of the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1181, as introduced, Escutia. Health care service plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Commissioner of Corporations.

Existing law requires every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, to include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status. Existing law defines ''primary care physician'' for purposes of this provision to mean a physician, as defined, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care, including providing for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. Existing law provides that an enrollee shall not be prohibited from selecting as a primary care physician any available primary care physician who contracts

with the plan in the service area where the enrollee lives or works. Existing law provides criminal sanctions for a violation of the provisions regulating health care service plans.

This bill would define ''primary care physician'' for the purposes of the provisions regulating health care service plans. Because the bill would change the definition of an existing crime, it would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law requires a county to ensure that each Medi-Cal or Aid to Families with Dependent Children (AFDC) program applicant or beneficiary who resides in the area served by a managed health care plan or pilot program in which beneficiaries can enroll, personally attends a presentation about the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. Existing law requires that the presentation provide the name, address, and telephone number of each primary care provider, by specialty, or clinic participating in each managed health care plan, pilot program, or fee-for-service case management provider option.

This bill would require that the name of each primary care provider or clinic be provided in alphabetical order.

Existing law sets forth procedures under which an applicant or beneficiary is generally required as a condition of coverage to choose between 2 health care options, obtain a Medi-Cal card and receive services from individual providers who provide services to Medi-Cal beneficiaries or enroll in a prepaid managed health care plan, pilot project, or fee-for-service case management provider option. These provisions require an applicant or beneficiary to choose a primary care provider under various circumstances.

This bill would define ''primary care provider'' for the purposes of these provisions relating to Medi-Cal and AFDC applicants or beneficiaries. This bill would, in certain instances where the provisions apply to a primary care provider, extend the application to a clinic.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) ''Advertisement'' means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) ''Basic health care services'' means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance services and out-of-area coverage.

(c) ''Enrollee'' means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) ''Evidence of coverage'' means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) ''Group contract'' means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) ‘‘Health care service plan’’ means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(g) ‘‘License’’ means, and ‘‘licensed’’ refers to, a license as a plan pursuant to Section 1353.

(h) ‘‘Out-of-area coverage,’’ for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan’s service area.

(i) *‘‘Primary care physician’’ means either of the following:*

(1) A general practitioner, including pediatricians and obstetrician-gynecologists.

(2) A specialist treating or who will be treating either one of the following:

(A) A person who is disabled as defined by any one of the following:

(i) Title XVI of the Social Security Act.

(ii) Section 51 of the Civil Code.

(iii) Section 233.80 of Title 45 of the Code of Federal Regulations.

(iv) Section 41-430 of the Eligibility and Assistance Standards of the State Department of Social Services; Manual of Policies and Procedures.

(B) A person who has a chronic medical condition for which regular treatment by a specialist is medically necessary.

(j) ‘‘Provider’’ means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

~~(j)~~

(k) ‘‘Person’’ means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

~~(k)~~

(l) ‘‘Service area’’ means a geographical area designated by the plan within which a plan shall provide health care services.

~~(l)~~

(m) ‘‘Solicitation’’ means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

~~(m)~~

(n) ‘‘Solicitor’’ means any person who engages in the acts defined in subdivision (k) of this section.

~~(n)~~

(o) ‘‘Solicitor firm’’ means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (k) of this section.

~~(o)~~

(p) ‘‘Specialized health care service plan contract’’ means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

~~(p)~~

(q) ‘‘Subscriber’’ means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

~~(q)~~

(r) Unless the context indicates otherwise, ‘‘plan’’ refers to health care service plans and specialized health care service plans.

~~(r)~~

(s) ‘‘Plan contract’’ means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

~~(s)~~

(t) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the commissioner.

~~(t)~~

(u) This section shall become operative April 1, 1993.

SEC. 2. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal or aid to families with dependent children (AFDC) applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall personally attend a presentation at which the applicant or beneficiary is informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary or applicant attends this presentation.

(b) The health care options presentation described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, *in alphabetical order, and the*

address, and telephone number of each primary care provider~~,~~ by specialty~~,~~ or clinic, *in alphabetical order,* participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. The name, address, and telephone number of each specialist participating in each prepaid managed care health plan, pilot project, or fee-for-service case management provider option shall be made available by either contacting the health care options contractor or the prepaid managed care health plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider *or clinic* contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot projects, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, who choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of

a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider *or clinic* contracting with the selected prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider *or clinic* shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan or pilot project or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service managed care provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service managed care provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider *or clinic*, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic ~~than~~ *that* it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(*l*) In areas where there is no prepaid managed health care plan or pilot program which has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) ''Applicant,'' ''beneficiary,'' and ''eligible applicant,'' in the case of a family group, means any person with legal authority to make a choice on behalf of dependent family members.

(2) ''Fee-for-service case management provider'' means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) ''Managed health care plan'' and ''managed care plan'' mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(4) "Primary care provider" means either of the following:

(1) A general practitioner, including a pediatrician and obstetrician-gynecologist.

(2) A specialist treating or who will be treating either one of the following:

(A) A person who is disabled as defined by any one of the following:

(i) Title XVI of the Social Security Act.

(ii) Section 51 of the Civil Code.

(iii) Section 233.80 of Title 45 of the Code of Federal Regulations.

(iv) Section 41-430 of the Eligibility and Assistance Standards of the State Department of Social Services; Manual of Policies and Procedures.

(B) A person who has a chronic medical condition for which regular treatment by a specialist is medically necessary.

(n) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

O